DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 15, 2022

Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: CCN: 245280
Cycle Start Date: July 14, 2022

Dear Administrator:

On August 3, 2022, we notified you a remedy was imposed. On September 1, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 31, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 18, 2022 be discontinued as of August 31, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 3, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 18, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 15, 2022

Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

Re: Reinspection Results
Event ID: 0DH812

Dear Administrator:

On September 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 14, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
August 3, 2022

Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: CCN: 245280
Cycle Start Date: July 14, 2022

Dear Administrator:

On July 14, 2022, a survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 18, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 18, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 18, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 18, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lakeview Methodist Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 18, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at

https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/11/22 through 7/14/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/11/22-7/14/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED WITH NO DEFICIENCY: H52803092C (MN84537), H52803136C (MN84906). The following complaints were found to be UNSUBSTANTIATED: H5280036C (MN72489), H52803068C (MN84690). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/08/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 609	It is the policy and procedure of Lakeview	7/18/22

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F 609	Continued From page 2 facility failed to report an allegation of abuse to the State Agency (SA) within 2 hours of the report for 1 of 3 residents (R22) who reported an allegation of potential abuse. Findings include: R22's significant change Minimum Data Set (MDS) assessment dated 6/18/22, indicated R22 had moderately impaired cognition, clear speech, was understood when he spoke and was able to understand others. R22 had adequate vision and minimal difficulty hearing. R22 required extensive assistance of one staff for most activities of daily living (ADLs). R22's care plan dated 5/6/22, indicated R22 was vulnerable to abuse and neglect due to nursing home placement and the need for assistance from staff. The care plan further indicated R22 would not suffer from abuse or neglect, and his safety needs would be met. Interventions included encouraging R22 to verbalize feelings and concerns, and staff would observe for mood, behavior, psychological needs and intervene as appropriate. During an interview on 7/11/22, at 6:10 p.m., R22 stated, "I'm not going to mention names...but there is one who is rougher than a cob" (R22 clarified he was referring to a corn cob), who tried to throw him around; happened in the morning or evening when getting up or going to bed. R22 stated it occurred when she (unknown staff person) was by herself; she would tell R22 to get up, and he would tell her he couldn't get up by himself. R22 stated he had not told anyone this as he hated to be a snitch. In addition, R22 stated he would not mention names; was not afraid of	F 609	Methodist that all residents are free from abuse, neglect, and maltreatment Resident #22 – interviewed a Vulnerability assessment was performed by LSW. Orders were requested for psych evaluation. Primary provider did not approve, as she does not feel he needs this at this time. Care plan was reviewed and revised by the interdisciplinary team. All Resident concerns, complaints and/or allegations of abuse, neglect and maltreatment are investigated are placed on a grievance form and are investigated with prompt action taken to protect all residents. ADM/DON/SW will review Grievances to ensure compliance with reporting, follow-up and resolution along with any trends identified. Abuse policy and procedures were reviewed. On 7/25/22, during the Resident Council meeting, SW read, explained and discussed with residents, the resident right Freedom from Abuse, Neglect and Exploitation. 7/18/22 All Nursing staff education re: Communication with people with Dementia, Communicating with those with hearing impairments and Strategies for assisting with ADL's. Education regarding facility Vulnerable Adult Plan Freedom from Abuse, Neglect and Exploitation will be provided to employees at the all employee meetings scheduled for 8/11/2022. Administrator will conduct interviews & resident experience surveys with all alert residents 1x monthly x4 months to ensure	

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F 609	Continued From page 3 retaliation and though he did not like being treated this way, was not going to say anything to anyone. On 7/11/22, at 6:45 p.m., R22's allegation of rough handling was reported to the director of nursing (DON). Facility policy titled Vulnerable Adult Plan, dated 11/1/17, indicated on page 10, there would be adequate supervision to identify inappropriate behaviors including rough handling. The process for internal investigation and reporting on pages 10 and 11, guided the process: the DON (director of nursing) or director of social services would be informed; a team would conduct an investigation to ensure the resident and other residents were safe from harm, and the resident, other residents and staff would be interviewed. External reporting on page 12, indicated alleged violations involving abuse or mistreatment would be reported immediately, but no later than two hours if the alleged violation involved abuse. A grievance form dated 7/11/22, (the time was left blank) completed by social worker (SW)-A indicated: --Summary: R22 voiced concern to surveyor regarding staff handled roughly. --Steps taken to investigate: 1) interviewed resident, 2) follow-up interview on 7/12, 3) staff interviews, 4) contact and inform son. --Findings: R22 said it was what they say to him ("you can do it" when I know I can't); it was not something physical. --Corrective action: message on communication board, nursing staff education on communication and approach with residents; re-education at monthly nursing meeting.	F 609	no allegations of abuse have occurred with results reported at QAPI. Administrator will audit reporting time frames of all VA allegations weekly for the next eight weeks to ensure that all reports are made within the appropriate time frame. Audit results will be reported to QAPI and action plans developed as needed. Administrator is responsible for compliance.	

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F 609	Continued From page 4 A progress note dated 7/12/2022, at 6:39 p.m., and written by social worker (SW)-A indicated: Follow up visit with resident after learning he had talked to a surveyor and there was some concern with his responses. Inquired with res[sident] about having people visit with him yesterday about his care here. Asked him if he had any concerns that I could help him with of which he said "I don't want to get anyone in trouble". Reassurance given that my goal is to make sure he is safe and taken care of and that the staff work here in his home and need to treat him with respect and dignity. I told him that I also hoped he could tell me his concern so that I can make sure it does not happen to others that live here. He said that he new [knew] I was a good person as I helped move his belonging to his new room and decorate it for him. As we talked he said that the staff was a female that was taller than me but that I am short like his 2nd wife was. He said that he was not sure of her hair color but she was proportioned to her height. Inquired if he recalls tattoo's on her arms as many staff have them and she did not. I asked if she works during the day and he said no. When I asked him if she hurt him he said "no, she was bossy though". Rephrased my question to ask if he felt he had been abused and he said "no, she was just bossy and didn't ask me but bossed me". Reassured him that he is safe here, that we do not want him to worry about his safety and that if this person continues to be bossy that he please let me know. Thanked him for sharing his concern and that his information will help us protect others as well. No other concerns noted. Consulted with LPN [licensed practical nurse] on duty who is not sure which staff this could be but will try to come up with who it may be so that we can talk with them	F 609		

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F 609	Continued From page 5 about how we speak to the residents and how we ask, explain and not boss them. During an interview on 7/13/22, at 1:33 p.m. with the DON, SW-A and (SW)-B, SW-A stated they reported allegations of abuse to the SA when they had enough information to validate that abuse occurred. SW-A admitted the facility did not report R22's allegation of potential abuse to the SA because the term R22 used -- "rough" -- meant different things to different people and did not necessarily imply abuse. The DON stated the reason the facility did not report potential abuse was because when R22 was interviewed by SW-A he denied being abused. Rather than report the allegation of abuse to the SA, SW-A completed a grievance form. At the conclusion of this interview, SW-A stated they would report the incident to the SA right away. The allegation of abuse by R22 was reported to the SA on 7/13/22, at 2:29 p.m. During an interview on 7/14/22, at 10:21 a.m., the DON reiterated that since R22 did not use the word abuse or identify his interaction with staff as abusive, the facility did not believe they needed to report the allegation of rough handling to the SA. Facility policy titled Vulnerable Adult Plan, dated 11/1/17, indicated there would be adequate supervision to identify inappropriate behaviors including rough handling. The process for internal investigation and reporting guided the process: the DON (director of nursing) or director of social services would be informed; a team would conduct an investigation to ensure the resident and other residents were safe from harm, and the resident, other residents and staff would be interviewed. External reporting indicated alleged	F 609		

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F 609	Continued From page 6 violations involving abuse or mistreatment would be reported immediately, but no later than two hours if the alleged violation involved abuse.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care to 1 of 2 resident (R22) reviewed for activities of daily living (ADL) and who was dependent upon staff for care. Findings include: R22's significant change Minimum Data Set (MDS) assessment dated 6/18/22, indicated R22 had moderately impaired cognition, clear speech, was understood when he spoke and was able to understand others. R22 had adequate vision and minimal difficulty hearing. R22 required extensive assistance of one staff for personal hygiene. R22's care plan dated 5/6/22, indicated an ADL self-care performance deficient requiring extensive assistance of one staff for grooming and personal hygiene. During an interview and observation on 7/11/22, at 6:24 p.m., observed fingernails on both hands approximately one quarter inch or more past the top of each finger on both hands. R22 stated he wanted his nails trimmed but didn't have a nail	F 677	Policy reviewed on 7/15/2022. Certified Nurse Aides and Nurses were educated on 7/14/2022. CNA-E was educated on 7/13/2022 in regards to policy of toenail trimming and nail trimming. Staff to continue to monitor nails and trim as necessary. Resident R22 did have his nails trimmed at time of survey. All resident's nails were checked and trimmed as necessary. Director of nursing and Resident care coordinators to will randomly audit nails to assure compliance. Audits will be completed and brought to quarterly QAPI meeting for review and acceptance. All negative findings will be reported to the DON/ RCC to be immediately addressed. All pertinent staff will be educated on nail trimming by Director of Nursing on 8/11/2022.	8/14/22

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	245280	A. BUILDING _____ B. WING _____	C 07/14/2022

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F 677	Continued From page 7 clipper. R22 denied staff had offered to trim his nails on his weekly bath day. During an observation on 7/13/22, at 8:15 a.m., R22 was sitting in his wheelchair eating breakfast and stated he just had a shower. Fingernails were unchanged from observation on 7/11/22. During an interview on 7/13/22, at 8:35 a.m., nursing assistant (NA)-E stated NA's trimmed resident fingernails if they were not diabetic, and this would typically be done on bath day or whenever a resident wanted it done. NA-E stated R22 had a shower by (NA)-D. During an interview on 7/13/22, a 9:03 a.m., (NA)-G stated resident fingernails were trimmed on bath day by a NA and R22 should have had his nails trimmed since he had a shower. NA-G looked at R22's fingernails and stated they were long and thick. NA-G stated if a NA was not comfortable trimming a residents nails, he/she could ask for help. During an interview on 07/13/22, at 9:11 a.m., registered nurse (RN)-C looked at R22's nails and asked R22 if he liked that length or if he wanted them trimmed. R22 motioned with his hands as if he were using a fingernail clipper. RN-C stated...you'd like them trimmed....we'll do that. RN-C stated she would have expected R22's nails be trimmed with his shower this week or last week, and acknowledged the length of his nails was more than just one or two weeks growth. At 10:01 a.m., RN-C reported that she trimmed R22's fingernails. During an interview on 7/14/22, at 8:12 a.m., (NA)-D stated she did not trim R22's nails with his	F 677		

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F 677	Continued From page 8 shower on 7/13, because she did not know if R22 was diabetic, adding she later learned it was toenails of diabetic residents she could not trim. NA-D stated she had cleaned under R22's nails and noticed they were long and had planned to trim them later that shift. NA-D acknowledged the growth of R22's nails did not occur in just the past week, stating "no, they were too long" for that to be the case. During an interview on 7/14/22, at 10:21 a.m., the director of nursing (DON) stated he expected staff to assist residents with nail care. The DON stated NA-D had planned to trim R22's fingernails later that shift on 7/13/22. The DON was informed R22's fingernails were very long and were not the result of missing one nail trimming. Facility policy titled Activities of Daily Living, undated, indicated in part that the purpose was to provide assistance to residents as necessary and to improve quality of life. The policy did not specify nail care for residents, such as who was responsible for nail care or when it would be completed.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		7/15/22

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F 686	Continued From page 9 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement pressure ulcer interventions for 1 of 1 resident (R9) reviewed for risk of pressure ulcer development. R9 was harmed when he developed one, stage 3 pressure ulcer after admission to the facility. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.). R9's facesheet printed on 7/13/22, indicated R9 was admitted on 8/2021; admission diagnoses included post-polio syndrome (disabling signs and symptoms that appear decades after initial polio illness, including muscle and joint weakness and loss of muscle) and dementia. R9's quarterly Minimum Data Set (MDS) assessment dated 4/6/22, indicated severe cognitive impairment, clear speech, was understood when he spoke and was able to understand others. R9 required extensive assistance of two staff and a mechanical lift for	F 686	It is the policy and procedure of Lakeview Methodist to assess and implement interventions and services to prevent and heal pressure injuries. Resident #9- Resident has been assessed for skin risk. Braden assessment performed 8/30/22. Resident was reviewed for pressure injury prevention interventions which include air mattress, along with foot cradle, Rooke boots, turning and offloading every 2 hours, frequent reapproach for repositioning, nutritional supplementation which are documented on the resident MAR daily. Resident was provided risk benefit discussion 8/30/22 regarding refusal of all pressure injury prevention interventions. Care plan and Kardex reviewed by interdisciplinary team. All residents are reviewed for changes in skin integrity with daily cares and weekly body checks with shower/bath. Any changes in resident skin integrity are reported to nurse and is communicated through shift to shift report and daily stand-up. With any alteration in skin integrity, the facility wound nurse is informed. Policy for prevention and treatment of pressure injuries was reviewed. 7/14/2022 all nurse aides were educated on nurse notification of redness to any area on the body observed during cares	

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F 686	Continued From page 10 moving in bed and toileting; was totally dependent upon two staff and a mechanical lift for transfers. R9 did not walk. The MDS assessment indicated R9 was at risk for pressure ulcer, but had no pressure ulcer over a bony prominence. In addition, the MDS assessment indicated a pressure reducing device in chair and bed was not used and there was not a turning/repositioning program in place for R9. R9's care plan dated 8/5/21 - 9/27/22, indicated R9 was at risk for an alteration in or potential for break in skin integrity. A goal indicated R9 would have no break in skin integrity through review date of 7/5/22. Interventions included daily skin inspections by a nursing assistant (NA) and to report abnormalities to the nurse, and to keep skin clean and dry. In addition, R9's care plan indicated he had an activity of daily living (ADL) self-care deficit related to post-polio syndrome and required extensive assistance of one to two staff to turn and reposition in bed as necessary. The care plan did not include measures to prevent a break in skin integrity, including, but not limited to, how often R9 should be turned and repositioned when in bed.. R9's care plan did not address off loading the heel and feet or device to protect ankles. Physician order dated 9/2/21, indicated: complete skin observation tool assessment weekly, every evening shift every Mon[day]. During a telephone interview on 7/12/22, at 8:12 a.m., family member (FM)-J stated R9 recently developed a pressure injury on left outer ankle, adding that R9 slept on his back with his left leg turned outward lying on the bed.	F 686	and with weekly bath, and for nurse to follow up and documentation on all residents with reporting to wound nurse the shift the alteration in skin integrity was noted. On 7/14/2022 Nursing staff also educated to document specific resident refusals on all residents and discussion of risks related to refusals in interventions. Resident Care Coordinator was educated on updating care plan interventions on 7/14/2022. All residents with alterations in skin integrity will be audited twice weekly for care plan updates and relief interventions in IDT and nursing administration meeting. Audits reflecting care plan review will be completed and brought to quarterly QAPI meeting for review and acceptance. All staff to be educated by DON on 8/11/2022.	

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F 686	Continued From page 11 Progress note dated 6/25/22, at 9:55 p.m., indicated licensed practical nurse (LPN)-B observed a stage 2 pressure area on R9's outer left malleolus (a bony projection on either side of the ankle). Noted while R9 in bed, laying on his back with left ankle rotated outward with outer ankle pressed into mattress. Weekly skin and wound evaluations for all of June and July were requested. No evaluations were received for 6/6 and 6/13. Others indicated: 6/20/22: No skin concerns noted. 6/25/22: Left outer ankle, pressure type injury, measuring in centimeters (cm): length 14.6, width 4, depth 0.1, stage II. In addition, the assessment indicated R9 was observed in bed, laying on his back with his left ankle rotated outward. 7/4/22: Left outer ankle, pressure type injury, measuring in cm: length 1.1, width 0.9, depth 0.1, stage II. 7/6/22: Left lateral malleolus 1.3 cm area; 1.3 cm length, 1.3 cm width. 7/11/22: R9 refused skin audit. 7/12/22: Left outer ankle, pressure type injury, measuring in cm: length 1, width 0.7, depth 0.1, stage III. Nurse practitioner (NP)-H visit note dated 6/28/22, indicated R9 had a reddened warm area on left ankle, painful with open area. Treatment being done. Open wound to left lateral malleolus. Scant drainage. No s/s [signs or symptoms] of infection. Keep heels elevated in bed. Referral to physical therapist (PT)-I to evaluate and treat wound. PT-I note dated 7/12/22, indicated R9 was seen for a stage 3 pressure injury to left mall [malleolus]. Current measurement 1 x 0.7 x 0.1	F 686		

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F 686	Continued From page 12 cm. Dressing change every two days with xeroform gauze and mepilex boarder dressing. Off-loading boot (blue) to be worn whenever in bed to off-load ankle. Recheck 10-14 days, sooner if wound size increases. During an interview on 7/12/22, at 2:23 p.m., license practical nurse (LPN)-C was aware of the pressure injury to R9's left ankle, stating it rotated outward when he laid in bed. LPN-C looked in the electronic medical record (EMR) to find first observation of pressure injury and stated it was on 6/25/22, at 9:55 p.m., when LPN-B observed a stage two pressure area on R9's outer left ankle. LPN-C was unaware of preventive measures that had been taken to prevent a pressure injury to R9, adding skin checks were done weekly on bath day. During an interview on 7/13/22, at 8:35 a.m., nursing assistant (NA)-E provided an untitled document she called a bath sheet. The document had five columns, including day of week, room number, resident name, skin audit day and bath day. NA-E stated R9 skin audits were done by NA's on the evening shift on Thursdays when R9 had a shower. NA-E stated NA's inform the nurse of any findings and the nurse documents findings in the EMR. NA-E had not given R9 a shower, as he preferred male staff. During an observation on 7/13/22, at 11:23 a.m., R9 was laying in bed supine (on back), covered with a towel following a shower. Left lateral ankle was covered with a dressing and left ankle was externally rotated with bony prominence directly resting on mattress. During an interview on 7/13/22, at 11:29 a.m.,	F 686		

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F 686	Continued From page 13 (LPN)-A stated R9's pressure injury was first noticed by a evening shift nurse on 6/25/22. LPN-A stated it was not noticed sooner because R9 refused skin audits. LPN-A stated if R9 refused, they would ask him again, but he had the right to refuse skin audits. LPN-A stated NA's looked at R9's skin daily as allowed and reported abnormalities to the nurse. LPN-A confirmed the only intervention on R9's care plan to prevent a pressure injury were daily skin checks by a NA. LPN-A acknowledged that would not prevent a pressure injury but might catch it before the skin broke. During a telephone interview on 7/13/22, at 12:29 p.m., PT-I confirmed she saw R9 on 7/12/22, and that he had a stage 3 pressure injury. PT-I stated that due to R9's history of polio, he lacked internal rotation of his left leg and was a high risk for a pressure injury because of that. PT-I could not say if the pressure injury was preventable, as she was unaware if the facility had been using preventive measures prior to discovering the wound. PT-I stated she gave R9 a off-loading boot for his left foot on 7/12/22. During an observation on 7/13/22, at 1:30 p.m. with LPN-A, observed R9's pressure injury to left lateral ankle. Visually, wound appeared to measure approximately .25 x .25 inches, pale yellow in center, no scab, no drainage. Skin surrounding wound was slightly red. LPN-A stated it was healing and looked better. Wound was flushed and dressed by LPN-A. A pressure reducing mattress on bed and pressure reducing cushion in wheelchair were observed; neither were noted on R9's care plan. During an observation on 7/14/22, at 7:50 a.m.,	F 686		

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F 686	Continued From page 14 R9 was laying in bed, supine. Off-loading boot noted on left foot. During an interview on 7/14/22, at 8:17 a.m., (NA)-D stated R9 "depends on us for everything." NA-D stated R9 might be able to turn onto his side in bed by himself, but would need a pillow behind his back to keep him on his side. "We are supposed to reposition him every two hours, but he usually refuses." In the EMR, in the section where NA's documented cares, NA-D displayed tasks for the surveyor to review, it identified repositioning every two hours and for skin observations. Skin observations were marked as "red areas" five times prior 6/25 (6/16, 6/18, 6/19, 6/22, 6/23), when the pressure injury was discovered. NA-D stated a NA could only checkmark red area, but not indicate where the red area was located, but if she observed a red area, she would tell a nurse. NA-D stated she had never observed redness on R9's outer left ankle when bathing or dressing him. During an interview on 7/14/22, at 8:56 a.m., registered nurse (RN)-E looked in the EMR to determine R9's pressure injury was first observed on 6/25/22. RN-E indicated she did not hear much from staff about things like this (pressure injury). RN-E did not know what preventative measures had been in place to prevent a pressure injury to R9's ankle, stating, "Honestly, I'm not sure." RN-E looked at R9's care plan in the EMR and stated there were no interventions to prevent pressure injury over bony prominence's ...only daily skin inspection and to keep R9's skin clean and dry. RN-E acknowledged she was aware of R9's post-polio syndrome diagnosis and stated the care plan only addressed that diagnosis as it related to activities	F 686		

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F 686	Continued From page 15 of daily living deficits. RN-E stated the facility used a program that automatically populated care plan interventions, and as staff got to know a resident better, they added more interventions. RN-E acknowledged that had not been done with R9's care plan regarding pressure injury prevention. RN-E stated skin audits were done by nurses and that ankles were a part of the audit, adding that nurses were supposed to go through each body part noted on schematic body drawings on the audit form. RN-E stated she did not know how R9's skin condition on his ankle was overlooked before becoming a stage 3 pressure injury. While looking at the NA task list in the EMR, RN-E stated NA's were to "shift and reposition R9 in bed or chair every two hours to reduce pressure," and stated this had not been added to R9's care plan and therefore nurses might not have been aware of it. On the same task list, NA's were to observe R9's skin for scratches, red areas, discoloration, skin tears, and open areas. In the days prior to 6/25, there were checkmarks made by NA's on six days for "red areas," but no corresponding documentation indicating whether or not a nurse had been informed of this, or where the red areas were located. RN-E acknowledged the pressure injury on R9's ankle was "probably" preventable, adding they could have floated his heels; he could have had heel boots. During an interview on 7/14/22, at 10:21 a.m., the DON confirmed he was aware of R9's pressure injury to his left ankle. Discussed the lack of measures initiated to prevent pressure injury over bony prominence's, as well as NA's checking "red areas" in their documentation for skin observation, but no correlating progress notes to indicate a nurse was informed and the location of	F 686		

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F 686	Continued From page 16 the red area. The DON acknowledged both were accurate. When asked if the pressure injury could have been prevented, the DON replied, "Ultimately, hindsight is 20/20.... probably could have been prevented...we've prevented a pressure injury for a long time, considering how often R9 refuses cares." Other than a pressure relieving mattress, there was no evidence that pressure reducing measures were in place to protect R9's skin over bony prominence's prior to discovery of a pressure injury on 6/25/22. While there were multiple notation in progress notes regarding refusals of care or of activities, none were observed regarding refusals to reposition in bed. Facility policy titled Skin Alteration Management, undated, indicated the facility would identify and review residents whose clinical conditions increase the risk for skin breakdown. To ensure necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and new injuries from developing. On admission, and quarterly, each resident would have a Braden assessment. Appropriate interventions would be implemented based on assessment and would be placed on resident care plan. Resident's skin would be observed daily with cares and as needed.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		8/10/22

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F 688	Continued From page 17 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 1 resident (R24) identified with limited range of motion of the right upper extremity (RUE). Findings include: R24's annual Minimum Data Set (MDS) assessment, dated 4/20/22; indicated R24 had moderately impaired cognition and functional limitations in activities of daily living (ADL); required extensive assistance with bed mobility, transferring, dressing, personal hygiene, and toileting. Furthermore, the MDS indicated R24 did not ambulate and used a wheelchair for mobility, had no impairment of extremities, and did not receive any therapy services for ROM. The MDS included diagnosis of history of falling, weakness, osteoarthritis (wearing down of protective tissue at the end of bones), restless leg syndrome (RLS) (a condition causing irresistible urge to move legs), anemia (lack of red blood cells), and Type 2 diabetes with polyneuropathy	F 688	It is the policy and procedure of Lakeview Methodist that ADL dependent residents receive the necessary cares and services. Resident #24 received OT orders and was evaluated on 8/10. Resident was given a diagnosis of Contracture Dupyutren□s on 8/30/2022, provider stated no further interventions at this time. OT trialed splints and resident refused splints. Resident was placed on a PROM program for bilateral hands BID. The resident care plan and Kardex has been reviewed and revised by IDT. All residents are reviewed daily with cares and biweekly by IDT for any changes in mobility or range of motion. Physician orders, and resident care plans were reviewed to ensure that all residents in need of range of motion assistance can receive it. The facility has formulated a plan that will ensure residents with limited range of motion do not experience a reduction in range of motion. Unless the resident□s	

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F 688	Continued From page 18 (a nerve disorder caused by diabetes). R24's occupational therapy (OT) weekly rehab meeting note, dated 6/1/21, indicated services provided for wheelchair seating and position mobility; had difficulty with traction after 3-inch wheelchair cushion was placed for self-propelling. R24's order summary, printed on 7/14/22, indicated standing orders for restorative nursing measures such as, passive range of motion (PROM), ambulation, transfers, and activities of daily living (ADL) may be implemented following an assessment by a licensed nurse. R24's care plan, printed on 7/14/22, indicated to monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function; physical therapy(PT)/OT evaluation and treatment as per MD orders, and to anticipate and meet the resident's needs. On 7/11/22 at 4:21 p.m., R24 was observed sitting in recliner chair in room. R24's bilateral hand was visualized to appear weak, slow to open. When R24 opened bilateral hand to extend fingers; right hand appeared tight, stiff, did not open completely as left hand. Right fifth finger appeared to curve inwards toward palm of hand. R24 indicated right hand didn't open as well as left hand did but didn't know why. R24 stated he was not receiving any therapy exercises for strengthening. During an interview, on 7/12/22 at 12:26 p.m., nursing aide (NA)-A indicated she was not aware of any restorative nursing services for R24. NA-A stated awareness of increased weakness to	F 688	clinical condition demonstrates that a reduction in range of motion is unavoidable. A resident with limited range of motion receives the appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. On 7/14/2022 nursing were staff educated on reporting and decline in mobility or change in dexterity, on range of motion movement and range of motion documentation. Residents with a change in mobility and/or dexterity will be referred to PT and OT for evaluation. Director of Nursing and/or the resident care coordinator will randomly audit documentation to verify ROM is being done. All pertinent staff will be educated for resident range of motion by Director of Nursing on 8/11/2022. Audits will be completed and brought to quarterly QAPI meeting for review and acceptance. All negative findings will be reported to the DON/ RCC to be immediately addressed. Director of Nursing is responsible for compliance.	

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F 688	Continued From page 19 R24's bilateral upper extremities (BUE's) over past 2 months. NA-A indicated when using E-Z stand for transfers, R24 was needing assistance from staff to assist with hand placement to grasp E-Z stand grab bars. When interviewed, on 7/12/22 at 1:06 p.m., NA-B indicated awareness of right hand being difficult to open since facility admission, had not worsened since then, overall mobility has declined approximately over last 6 months. NA-B stated she was not aware if R24 had been receiving any OT or PT, aware R24 was supposed to have ROM exercises completed, as done on all residents. NA-B indicated unawareness of specific exercise regimen to be completed for R24. During an interview, on 7/12/22 at 01:42 p.m., registered nurse (RN)-A indicated R24's hands were becoming more "fixed," mobility declined and was no longer ambulatory. RN-A stated awareness R24 had PRN (as needed) restorative nursing order for implementation of ROM. RN-A verified no restorative nursing order for ROM had been implemented for R24 at that time, needed to complete a resident assessment first by one of the resident care coordinators (RCCs). When interviewed, on 7/12/22 at 2:49 p.m., RN-E indicated unawareness of any ROM or mobility concerns to R24's BUE's, except a trigger finger to right 5th finger to right hand. RN-E stated all residents had assessments completed, including mobility; assessments completed at time of admission, quarterly, and at discharge. RN-E indicated she had just recently completed R24's quarterly assessment this month, (July 2022),	F 688		

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F 688	Continued From page 20 had no concerns with ROM or mobility at time of assessment. During an interview, on 7/12/22 at 3:15 p.m., occupational therapy aide (OTA) indicated R24 was evaluated on 6/1/21 for wheelchair seating/positioning, no other evaluations since that time. OTA stated per 6/1/21 OT notes, no evaluation or recommendations were provided regarding ROM/mobility needs for R24's BUE's. A mobility assessment was completed for R24's BUE's per RN-E on 7/13/22 at 9:32 a.m. RN-E indicated no concerns for R24's left hand. RN-E stated R24's right hand had a firm grasp; when opening hand and extending fingers, R24 could only extend fingers half-way, right 5th finger remained curved inward. RN-E indicated during assessment, she could feel rigidity and tightness to R24's right hand with extension of fingers. RN-E confirmed R24 had contraction to right hand, did not know why she hadn't noticed that previously. RN-E indicated she would request an order from physician to have R24 evaluated per OT to assess strength and possible contracture of right hand. On 7/13/22 at 11:50 a.m., PT-E was requested per surveyor to assess R24's ROM and mobility to right hand, as OT not available at time. PT-E indicated inability to evaluate R24's ROM and mobility status to right hand without having a physician's order. When interviewed, on 7/13/22 at 1:16 p.m., the director of nursing (DON) indicated resident's ROM and mobility were assessed at time of admission, quarterly, and at time of discharge per RCCs. The DON further stated staff could ask	F 688		

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F 688	Continued From page 21 PT/OT to evaluate a resident's ROM or mobility status if needing to be determined right away, like a transfer status. The DON indicated if staff noticed a change in a resident's ROM or mobility condition, expectation was for staff to notify licensed nursing right away, licensed nurse would document findings in progress note through electronic medical record (EMR) system, send a request to resident's physician asking for PT/OT orders to evaluate, and implement standing orders for restorative ROM program to prevent further decline in ROM/mobility. Facility policy and procedure titled, "Range of Motion (Active, Active Assistance, and Passive)," undated, included; purpose to move the resident's joints through as full a range of motion as possible, to improve or maintain joint mobility and muscle strength, to prevent contractures, to increase strength and activity tolerance, to prevent complications of mobility. General; assess the resident for disability, pain, and weakness. Special considerations; inform nurse of any changes in resident's ability, when the resident's activity level or joint function is at risk of or decreases range of motion should be started as soon as possible joints begin to stiffen within 24 hours of disuse. Possible related minimum data set triggers; ADL function/rehabilitation potential, psychosocial well-being, falls, psychotropic drug use.	F 688		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		7/15/22

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F 880	Continued From page 22 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 23 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain a system to analyze monthly surveillance data for trends and patterns to reduce the spread of illness, infections, control transmission of infections and communicable diseases present in the facility, review annually the infection prevention and control program (IPCP), and the facility failed implement measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms. This had the potential to affect all 57 residents who resided in the facility.	F 880	Resident #286 □ Discharged -FM-A was also educated on PPE 7/11/22. Resident #2- as added to the current line listing of infections and antibiotic tracking tool spreadsheet to bring it current on 7/13/2022. Alternate plan for disposal of PPE upon exit of room (In separate trash bag) developed as resident does not wish to have garbage can in room for used PPE. Infection control nurse educated staff on 7/11/2022 regarding proper doffing of PPE for Res#2. Care plan and Kardex was reviewed and revised by the facility IDT. All residents who are on	

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F 880	Continued From page 24 Findings include: Surveillance: Review of the facility's infection tracking sheets dated April 2022, to July 2022, indicated: resident, floor/wing, room number, infection type, body system of infection, community onset, facility onset, symptoms, onset date, device type, infection risk factors, collection date, type of test, specimen source, results (organism colony counts for urine), antibiotic resistant organism, number of different antibiotics currently prescribed, drug (dose, route frequency), total days of therapy, antibiotic times outs performed, total days of therapy, transmission based precautions required, date symptoms resolved. The facility tracking sheets dated April 2022, to July 2022, indicated missing data fields on the tracking sheets, and further lacked an analysis of the infections/illness, patterns or trends, interventions implemented, and transmission based precautions required. The facility did not provide analysis of the infections to include trending, patterns and what interventions were implemented, if patterns or trends were identified. The facility further failed to identify surveillance of R2's Clostridium difficile (infection of the large intestine) and transmission based precautions. R2's lab information dated 4/20/22, indicated a positive C. difficile toxin. On 7/13/21, at 1:04 p.m. an interview with registered nurse (RN)-B indicated she was the infection nurse at the facility. RN-B verified she tracked and documented infections on the computer tracking form, but no ongoing "formal" surveillance, monitoring of trends and/or breaks in infection practices had occurred more then	F 880	transmission-based precautions have been reviewed for appropriate trash receptacle in room for PPE and for appropriate signage. For all residents under quarantine and/or isolation signage will be provided in room and upon admission. Root cause analysis for PPE Procedure and Surveillance compliance have been performed and reviewed at QAPI on 8/3/22. Policy and procedures reviewed and revised for gowns, masks, and for surveillance according to DPOC. Education provided to all staff, residents and resident representatives on infection control program along with appropriate use of PPE Donning and Doffing. Infection control nurse to perform surveillance with all infections on infection and antibiotic tracking tool spreadsheet. Medical Director will be updated with any increase in infections or concerns. IP provided education to desk nurses on tracking of all infections in current line listing, both infections that are being treated with antibiotics and those not being treated by antibiotics on the spread sheet. All infections will be reviewed daily tracked and monitored for trends, investigated as needs, along with monthly analysis for trends. The facility DON/designee will review daily the infection listing and will serve as a back-up to IP. DON/designee will audit weekly for compliance with infection line listings weekly x4 and will review audits at facility QAPI meeting along with random audits of gowning, mask use and signage	

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F 880	Continued From page 25 quarterly. RN-B indicated infection data was reviewed on a quarterly basis to report the infection rate to the quality committee. When asked to review the infection data, RN-B used the tracking form on the computer and identified the infection control logs for the past few months. RN-B confirmed the some of the data was missing from the tracking logs. RN-B verified anything she had done regarding infection prevention was on done on an "informal" basis. RN-B indicated daily she discussed residents on antibiotics with facility staff; however, residents were not tracked or compared for trending's or patterns. RN-B verified a monthly analysis of the illness' and infections was important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. RN-B indicated R2 was not on the surveillance tracking sheet. RN-B verified R2 was expected to be on the surveillance tracking sheet starting April 2022, and was expected to be on the current tracking log dated July 2022, due to R2 continued transmission based precautions, C-diff diagnoses, and symptoms of diarrhea. On 7/14/22, at 10:32 a.m. the director of nursing (DON) indicated the facility was expected to track, trend and analyze potential and actual infections of residents; and further indicated the current facility practice was to analyze the data collected from the tracking log and summarize the information quarterly. The information was then brought to the quality assurance meeting and discussed on a quarterly basis. The DON confirmed R2 was expected to be on the tracking log due to transmission based precautions and diagnosis of C-Diff.	F 880	placement. Audits of surveillance, and gowning (DONNING/DOFFING), mask use, and signage placement will be done weekly at random and brought to QAPI meeting for review and acceptance. Director of Nursing is responsible for compliance.	

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F 880	Continued From page 26 Policy titled Transmission Based Precautions dated 4/13/22, indicated: Surveillance and Outbreak Management 1. In order to detect outbreaks early and monitor the effectiveness of these policies: a. confidential line listing of residents known to carry antibiotic resistant microorganisms (ARM) should be maintained. b. Surveillance of cultures obtained for clinical reasons should be reviewed regularly to determine if nososcomial transmission has occurred. 2. An outbreak is defined as: a. three or more cases of clinically significant facility acquired infections caused by the same Organism occurring in the same general area within up. Of seven days or b. twice that normal number of these infections per month observer period of three consecutive months Policy Titled Antibiotic Stewardship Program dated 5/17/18, indicated: -Stewardship actions are conducted to enable or to measure these key elements of care knowing when to be concerned about their infection and or resident what clinical and historical information to gather for the provider, when does submit diagnostic specimens to the laboratory, how to quantify and assess appropriateness of antibiotics prescribed, and how do I identify adverse outcomes that might be associated with antibiotics. actions put into place Find the antibiotic stewardship team will be monitored monthly (see measuring actions section of this document), discuss with leadership and appropriate consulting experts and reviewed for necessary updates annually.	F 880		

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F 880	Continued From page 27 Actions: -Prescription record keeping dose duration route and indication of every antibiotic must be documentation in the electronic medical record for every resident regardless of prior prescriptions or documentation elsewhere. location of this information should be made on the day that the prescription is written or on the day the resident returns the facility on an antibiotic prescribed elsewhere. records will be reviewed monthly to assess compliance with this requirement as well as prescription appropriateness for the individual resident site and type of infection. Tracking a. Measurement/tracking objectives: we will monitor antibiotic use stewardship actions and outcomes related to antibiotic use in order to guide change and track antibiotics to recheck program impact b. what will be measured tracked i. antibiotic use: antibiotic starts ii. stewardship actions: record keeping protocol compliance iii. Outcomes: C difficile and MRSA detection c. Measurements: i. Antibiotic use: days of therapy ii. stewardship actions: record keeping protocol compliance and compliance with urine specimen submission guidelines iii. outcomes: C difficile MRSA infections urinary tract infections and antibiotic cost Infection prevention and control program (IPCP): Review of the facility infection prevention and control program (IPCP) dated 3/23/21, indicated manual and policies reviewed.	F 880		

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F 880	Continued From page 28 On 7/13/21, at 1:04 p.m. an interview RN-B confirmed the IPCP was last reviewed on 3/21/21, and verified IPCP were expected to be reviewed annually. Personal Protective Equipment (PPE): During observation on 7/11/22, at 12:33 p.m. observed an unidentified staff exit R208's room, removed PPE that included gown, gloves, N-95 mask, and face shield, and removed and discarded contaminated gown into a container that would not close due to overfilled with other yellow gowns. During observation on 7/11/22, at 12:40 p.m., 12 feet outside of R2's room a cart with drawers with clean PPE supplies was observed, and on each side of the clean PPE supplies a container for dirty linens and dirty PPE supplies was observed. R2's room was observed and failed to have signage posted regarding transmission based precautions, and R2's room did not have garbage for staff to remove contaminated PPE prior to exiting the room. During interview on 7/11/22, at 1:57 p.m., RN-B indicated staff received training on donning and doffing PPE. RN-B stated staff were taught to take all PPE off inside the room and stated staff were expected to take off PPE prior to exiting the resident's room. RN-B stated the garbage's to dispose of PPE were expected in the residents room not outside the resident's room. On 7/11/22, at 2:20 p.m. R258's family member was observed in R258's room, and wore a PPE gown and FM-A was observed to exit the room, walked down unit hallway with isolation gown,	F 880		

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F 880	Continued From page 29 stopped at unit coffee machine, lifted lever to coffee machine, poured coffee into Styrofoam cup. FM-A returned to R258's room, opened door, and closed door behind her once in room. Outside of R258's room, observed 2 garbage cans outside of resident room, one labeled "soiled," had red bag lining garbage can and other not labeled, had regular plastic lining garbage can. Noted yellow isolation gowns, gloves, N95 masks in regular garbage can. Next to garbage cans was a clean PPE cart with supplies. On 7/12/22, at 11:11 a.m. nursing assistant (NA)-C, indicated R2 was on precautions for C-diff, and indicated staff were expected to wear gown and gloves, when they assisted with R2 with toileting. NA-C further indicated residents who are newly admitted to the facility were isolated their room for 14 days, and staff were expected to wear PPE including gowns, gloves, face, shield, N95 when going to the room, and the PPE was discarded when exiting the room not in the room. On 7/12/22, at 1:07 p.m. registered nurse (RN)-A came out of R258's room, had yellow isolation gown on over scrubs, gloves, N95 mask, face shield and discarded PPE in regular garbage can outside of R258's room. On 7/13/22, at 9:14 a.m. RN-A indicated R258 was on isolation precautions due to not up to date with COVID booster immunization. RN-A indicated would not expect R258;s family member walk around hallway/dining area with isolation gown/mask after she came out of R258's isolation room. RN-A further indicated with PPE garbage cans outside of room, there is potential if	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 07/14/2022

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F 880	Continued From page 30 R258 was infectious, would pose risk for transmission of infections to others and RN-A indicated garbage cans should be inside R258's room for potential exposure/cross-contamination. On 7/13/22, at 9:49 a.m. RN-C indicated FM-A was not expected walking throughout facility with isolation gown/mask after coming out of R258's isolation room. RN-C stated staff were expected provide education with FM-A to remain in the room until ready to leave facility. During a follow up interview on 7/13/22, at 1:04 p.m. RN-B indicated R2 did not want signage on her door related to transmission based precautions, and did not want the garbage in her room for PPE discarded, when asked how other resident's would be protected RN-B indicated she was not sure what the policy stated and staff were educated on 7/12/22, remove PPE just inside doorway, dispose of in bag, and tie securely, proceed to receptacle in hallway and sanitize hands after disposing . RN-B confirmed prior to 7/12/22, staff were removing PPE outside of R2's doorway. During interview on 7/14/22, at 10:32 a.m. the director of nursing confirmed staff should not be coming out of the room to discard the gowns. Progress note dated 7/11/22, at 4:24 p.m. RN-B indicated R2's receptacles for laundry and garbage are too far out into the hall for IC (infection control) best practice. R2 does not want them in her room or closer to the door, she refuses signage on her door. New procedure to ensure good IC will be: take a garbage bag from drawer in bathroom, proceed to door way,	F 880		

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F 880	Continued From page 31 remove PPE just inside doorway, dispose of in bag, and tie securely. Proceed to receptacle in hallway and sanitize hands after disposing. Please do the same with laundry,. Policy titled Transmission-Based Precautions dated 4/13/22, indicated: Gowns 1. DON gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident care environment. 2. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental services that could result in possible transfer microorganism to other residents environmental services. 3. for all residents gowns should be worn as necessary for standard precautions. 4. In addition, a clean, non sterile gown with long sleeves will be worn if direct care will be provided or when substantial contact with secretions/excretions is anticipated when such contact is anticipated the gown should be put on before entering the room or approaching the resident 5. Gowns should also be worn when body contact with environmental services and items in the room that may be contaminated is anticipated. Particularly if the resident is incontinent of urine or stool or has diarrhea 6. The gown will be removed and appropriately discarded before leaving the residents environment. 7. After gown removal, staff should ensure that clothing does not potentially contaminate environmental services to avoid transfer microorganisms to other residents or environments.	F 880		

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F 880	Continued From page 32 Policy and procedure title personal protective equipment- gowns, aprons and lab coats dated 10/14/21, indicated: -When gowns are used, they must be used only once and discarded into appropriate receptacles located in the room in which the procedure is performed. Staff Training document titled Infection Control: Essential Principles dated 2020, indicated: -Perform hand hygiene and put on gloves before you enter the persons room. for some tasks you may need to wear a gown. before you leave the room remove your gloves and your gown and perform hand hygiene these precautions apply to family and other visitors as well.	F 880		

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	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**07/13/2022**

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/13/2022. At the time of this survey, Lakeview Methodist Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/08/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakeview Methodist Healthcare Center is identified as Building 02 for this survey. It was constructed in 2021, is two-story, with a basement, is fully fire sprinkler protected and is of Type II(111) construction. This new construction consists of a 79,784 sq ft. new replacement Skilled Nursing Facility. The building has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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K 000	Continued From page 2 corridors which is monitored for automatic fire department notification. The building has automatic smoke detection in all Patient Rooms. The facility has a capacity of 72 beds at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, that facility failed to test emergency egress lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/13/2022, between 10:00 AM and 12:00 PM, it was revealed by a review of the available documentation that there were no records available to review to show that the 30-second test on emergency lights took place from January thru June 2022. An interview with the Maintenance Director verified this finding at the time of discovery.	K 291	In our morning meeting we discussed the existence of battery backup lighting. We did a full walk-thru and verified all existing battery back up lighting and on July 14th, w0ww created an emergency battery backup lighting monthly/annual check sheet. Immediately did a full check on all lights. Placed the check list into our monthly check binder for all walk-through's. Building supervisor emailed the document showing immediate attention to the documentation deficiency to Fir Marshall Larry Gannon. TO ensure the system checks are done in a timely fashion, we have placed a checklist for one of our maintenance men (Mark Schott) to perform. Mark Hughes, Building supervisor, will revisit each month at our morning meetings to ensure and	7/14/22

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K 291	Continued From page 3	K 291	monitor that the system checks are being done. The actual completion of this deficiency and documentation for future checks were set on 7/14/2022.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 3, 2022

Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

Re: State Nursing Home Licensing Orders
Event ID: 0DH811

Dear Administrator:

The above facility was surveyed on July 11, 2022 through July 14, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	C 07/14/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/11/22 through 7/14/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders, and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED WITH NO DEFICIENCY: H52803092C (MN84537), H52803136C (MN84906). The following complaints were found to be UNSUBSTANTIATED: H5280036C (MN72489), H52803068C (MN84690). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 1 resident (R24)	2 895	Facility has formulated a plan that will ensure residents with limited range of motion do not experience a reduction in	8/10/22

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2 895	Continued From page 3 identified with limited range of motion of the right upper extremity (RUE). Findings include: R24's annual Minimum Data Set (MDS) assessment, dated 4/20/22; indicated R24 had moderately impaired cognition and functional limitations in activities of daily living (ADL); required extensive assistance with bed mobility, transferring, dressing, personal hygiene, and toileting. Furthermore, the MDS indicated R24 did not ambulate and used a wheelchair for mobility, had no impairment of extremities, and did not receive any therapy services for ROM. The MDS included diagnosis of history of falling, weakness, osteoarthritis (wearing down of protective tissue at the end of bones), restless leg syndrome (RLS) (a condition causing irresistible urge to move legs), anemia (lack of red blood cells), Type 2 diabetes with polyneuropathy (a nerve disorder caused by diabetes), chronic kidney disease (CKD)- stage 4, and atrial fibrillation (irregular heartbeat). R24's occupational therapy (OT) weekly rehab meeting note, dated 6/1/21, indicated services provided for wheelchair seating and position mobility; had difficulty with traction after 3-inch wheelchair cushion was placed for self-propelling. R24's order summary, printed on 7/14/22, indicated standing orders for restorative nursing measures such as, passive range of motion (PROM), ambulation, transfers, and activities of daily living (ADL) may be implemented following an assessment by a licensed nurse. R24's care plan, printed on 7/14/22, indicated to monitor/document/report as needed (PRN) any	2 895	range of motion. Unless the resident□s clinical condition demonstrates that a reduction in range of motion is unavoidable. R24 received OT orders. A resident with limited range of motion receives the appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. On 7/14/2022 nursing staff educated on range of motion movement and documentation, staff also educated on updating nurse if there is a change in dexterity and mobility from baseline. Physician orders, and resident care plans were reviewed to ensure that all residents in need of range of motion assistance can receive it. Director of Nursing and/or the resident care coordinator will randomly audit documentation to verify ROM is being done. Audits will be completed and brought to quarterly QAPI meeting for review and acceptance. All negative findings will be reported to the DON/ RCC to be immediately addressed. All pertinent staff will be educated for resident range of motion by Director of Nursing on 8/11/2022.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 4 changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function; physical therapy(PT)/OT evaluation and treatment as per MD orders, and to anticipate and meet the resident's needs. On 7/11/22 at 4:21 p.m., R24 was observed sitting in recliner chair in room. R24's bilateral hand was visualized to appear weak, slow to open. When R24 opened bilateral hand to extend fingers; right hand appeared tight, stiff, did not open completely as left hand. Right fifth finger appeared to curve inwards toward palm of hand. R24 indicated right hand didn't open as well as left hand did but didn't know why. R24 stated he was not receiving any therapy exercises for strengthening. During an interview, on 7/12/22 at 12:26 p.m., nursing aide (NA)-A indicated she was not aware of any restorative nursing services for R24. NA-A stated awareness of increased weakness to R24's bilateral upper extremities (BUE's) over past 2 months. NA-A indicated when using E-Z stand for transfers, R24 was needing assistance from staff to assist with hand placement to grasp E-Z stand grab bars. When interviewed, on 7/12/22 at 1:06 p.m., NA-B indicated awareness of right hand being difficult to open since facility admission, had not worsened since then, overall mobility has declined approximately over last 6 months. NA-B stated she was not aware if R24 had been receiving any OT or PT, knew R24 was supposed to have ROM exercises completed, as done on all residents. NA-B indicated unawareness of specific exercise regimen to be completed for R24.	2 895		

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2 895	Continued From page 5 During an interview, on 7/12/22 at 01:42 p.m., registered nurse (RN)-A indicated R24's hands were becoming more "fixed," mobility declined and was no longer ambulatory. RN-A stated awareness R24 had a PRN restorative nursing order for implementation of ROM. RN-A verified no restorative nursing order for ROM had been implemented for R24 at that time, needed to complete a resident assessment first by one of the resident care coordinators (RCCs). When interviewed, on 7/12/22 at 2:49 p.m., RN-E indicated unawareness of any ROM or mobility concerns to R24's BUE's, except a trigger finger to right 5th finger to right hand. RN-E stated all residents had assessments completed, including mobility; assessments completed at time of admission, quarterly, and at discharge. RN-E indicated she had just recently completed R24's quarterly assessment this month, (July 2022), had no concerns with ROM or mobility at time of assessment. During an interview, on 7/12/22 at 3:15 p.m., occupational therapy aide (OTA) indicated R24 was evaluated on 6/1/21 for wheelchair seating/positioning, no other evaluations since that time. OTA stated per 6/1/21 OT notes, no evaluation or recommendations were provided regarding ROM/mobility needs for R24's BUE's. A mobility assessment was completed for R24's BUE's per RN-E on 7/13/22 at 9:32 a.m. RN-E indicated no concerns for R24's left hand. RN-E stated R24's right hand had a firm grasp; when opening hand and extending fingers, R24 could only extend fingers half-way, right 5th finger remained curved inward. RN-E indicated during assessment, she could feel rigidity and tightness to R24's right hand with extension of fingers.	2 895		

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2 895	Continued From page 6 RN-E confirmed R24 had contraction to right hand, did not know why she hadn't noticed that previously. RN-E indicated she would request an order from physician to have R24 evaluated per OT to assess strength and possible contracture of right hand. On 7/13/22 at 11:50 a.m., PT-E was requested per surveyor to assess R24's ROM and mobility to right hand, as OT not available at time. PT-E indicated inability to evaluate R24's ROM and mobility status to right hand without having a physician's order. When interviewed, on 7/13/22 at 1:16 p.m., the director of nursing (DON) indicated resident's ROM and mobility were assessed at time of admission, quarterly, and at time of discharge per RCCs. The DON further stated staff could ask PT/OT to evaluate a resident's ROM or mobility status if needing to be determined right away, like a transfer status. The DON indicated if staff noticed a change in a resident's ROM or mobility condition, expectation was for staff to notify licensed nursing right away, licensed nurse would document findings in progress note through electronic medical record (EMR) system, send a request to resident's physician asking for PT/OT orders to evaluate, and implement standing orders for restorative ROM program to prevent further decline in ROM/mobility. Facility policy and procedure titled, "Range of Motion (Active, Active Assistance, and Passive)," undated, included; purpose to move the resident's joints through as full a range of motion as possible, to improve or maintain joint mobility and muscle strength, to prevent contractures, to increase strength and activity tolerance, to prevent complications of mobility.	2 895		

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2 895	Continued From page 7 General; assess the resident for disability, pain, and weakness. Special considerations; inform nurse of any changes in resident's ability, when the resident's activity level or joint function is at risk of or decreases range of motion should be started as soon as possible joints begin to stiffen within 24 hours of disuse. Possible related minimum data set triggers; ADL function/rehabilitation potential, psychosocial well-being, falls, psychotropic drug use. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could schedule an in-service to address the importance of residents receiving appropriate treatment and services for range of motion limitations. An assessment and appropriate treatment intervention plan could be provided by the staff for these residents. A monitoring program could be established in order to assure an on-going effective rehabilitative program for residents with range of motion needs/services. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical	2 900		7/15/22

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2 900	Continued From page 8 condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement pressure ulcer interventions for 1 of 1 resident (R9) reviewed for risk of pressure ulcer development. R9 was harmed when he developed one, stage 3 pressure ulcer after admission to the facility. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.). R9's facesheet printed on 7/13/22, indicated R9 was admitted on 8/2021; admission diagnoses included post-polio syndrome (disabling signs and symptoms that appear decades after initial polio illness, including muscle and joint weakness and loss of muscle) and dementia. R9's quarterly Minimum Data Set (MDS) assessment dated 4/6/22, indicated severe	2 900	Staff to continue with current air mattress intervention for pressure relief while in bed. Staff continue to offer foot cradle, Rooke boots and off-loading interventions, to be documented on the MAR daily by nurse. Care plan interventions were updated with wounds and to include pressure relief interventions and will also include frequently offered and refused interventions. Certified Nurse Aid Kardex was also reviewed. On 7/14/2022 all CNA□s were educated on nurse notification of redness to any area on the body, and for nurse to follow up and documentation on all residents. On 7/14/2022 Nursing staff also educated to document specific resident refusals on all residents. Resident Care Coordinator was educated on updating care plan interventions on 7/14/2022. All residents with wounds will be audited weekly for care plan updates and relief interventions. Audits will be completed and brought to quarterly QAPI meeting for review and acceptance. All staff to be educated by DON on 8/11/2022.	

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2 900	Continued From page 9 cognitive impairment, clear speech, was understood when he spoke and was able to understand others. R9 required extensive assistance of two staff and a mechanical lift for moving in bed and toileting; was totally dependent upon two staff and a mechanical lift for transfers. R9 did not walk. The MDS assessment indicated R9 was at risk for pressure ulcer, but had no pressure ulcer over a bony prominence. In addition, the MDS assessment indicated a pressure reducing device in chair and bed was not used and there was not a turning/repositioning program in place for R9. R9's care plan dated 8/5/21 - 9/27/22, indicated R9 was at risk for an alteration in or potential for break in skin integrity. A goal indicated R9 would have no break in skin integrity through review date of 7/5/22. Interventions included daily skin inspections by a nursing assistant (NA) and to report abnormalities to the nurse, and to keep skin clean and dry. In addition, R9's care plan indicated he had an activity of daily living (ADL) self-care deficit related to post-polio syndrome and required extensive assistance of one to two staff to turn and reposition in bed as necessary. The care plan did not include measures to prevent a break in skin integrity, including, but not limited to, how often R9 should be turned and repositioned when in bed.. R9's care plan did not address off loading the heel and feet or device to protect ankles. Physician order dated 9/2/21, indicated: complete skin observation tool assessment weekly, every evening shift every Mon[day]. During a telephone interview on 7/12/22, at 8:12 a.m., family member (FM)-J stated R9 recently developed a pressure injury on left outer ankle,	2 900		

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2 900	Continued From page 10 adding that R9 slept on his back with his left leg turned outward lying on the bed. Progress note dated 6/25/22, at 9:55 p.m., indicated licensed practical nurse (LPN)-B observed a stage 2 pressure area on R9's outer left malleolus (a bony projection on either side of the ankle). Noted while R9 in bed, laying on his back with left ankle rotated outward with outer ankle pressed into mattress. Weekly skin and wound evaluations for all of June and July were requested. No evaluations were received for 6/6 and 6/13. Others indicated: 6/20/22: No skin concerns noted. 6/25/22: Left outer ankle, pressure type injury, measuring in centimeters (cm): length 14.6, width 4, depth 0.1, stage II. In addition, the assessment indicated R9 was observed in bed, laying on his back with his left ankle rotated outward. 7/4/22: Left outer ankle, pressure type injury, measuring in cm: length 1.1, width 0.9, depth 0.1, stage II. 7/6/22: Left lateral malleolus 1.3 cm area; 1.3 cm length, 1.3 cm width. 7/11/22: R9 refused skin audit. 7/12/22: Left outer ankle, pressure type injury, measuring in cm: length 1, width 0.7, depth 0.1, stage III. Nurse practitioner (NP)-H visit note dated 6/28/22, indicated R9 had a reddened warm area on left ankle, painful with open area. Treatment being done. Open wound to left lateral malleolus. Scant drainage. No s/s [signs or symptoms] of infection. Keep heels elevated in bed. Referral to physical therapist (PT)-I to evaluate and treat wound. PT-I note dated 7/12/22, indicated R9 was seen	2 900		

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2 900	Continued From page 11 for a stage 3 pressure injury to left mall [malleolus]. Current measurement 1 x 0.7 x 0.1 cm. Dressing change every two days with xeroform gauze and mepilex boarder dressing. Off-loading boot (blue) to be worn whenever in bed to off-load ankle. Recheck 10-14 days, sooner if wound size increases. During an interview on 7/12/22, at 2:23 p.m., license practical nurse (LPN)-C was aware of the pressure injury to R9's left ankle, stating it rotated outward when he laid in bed. LPN-C looked in the electronic medical record (EMR) to find first observation of pressure injury and stated it was on 6/25/22, at 9:55 p.m., when LPN-B observed a stage two pressure area on R9's outer left ankle. LPN-C was unaware of preventive measures that had been taken to prevent a pressure injury to R9, adding skin checks were done weekly on bath day. During an interview on 7/13/22, at 8:35 a.m., nursing assistant (NA)-E provided an untitled document she called a bath sheet. The document had five columns, including day of week, room number, resident name, skin audit day and bath day. NA-E stated R9 skin audits were done by NA's on the evening shift on Thursdays when R9 had a shower. NA-E stated NA's inform the nurse of any findings and the nurse documents findings in the EMR. NA-E had not given R9 a shower, as he preferred male staff. During an observation on 7/13/22, at 11:23 a.m., R9 was laying in bed supine (on back), covered with a towel following a shower. Left lateral ankle was covered with a dressing and left ankle was externally rotated with bony prominence directly resting on mattress.	2 900		

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2 900	Continued From page 12 During an interview on 7/13/22, at 11:29 a.m., (LPN)-A stated R9's pressure injury was first noticed by a evening shift nurse on 6/25/22. LPN-A stated it was not noticed sooner because R9 refused skin audits. LPN-A stated if R9 refused, they would ask him again, but he had the right to refuse skin audits. LPN-A stated NA's looked at R9's skin daily as allowed and reported abnormalities to the nurse. LPN-A confirmed the only intervention on R9's care plan to prevent a pressure injury were daily skin checks by a NA. LPN-A acknowledged that would not prevent a pressure injury but might catch it before the skin broke. During a telephone interview on 7/13/22, at 12:29 p.m., PT-I confirmed she saw R9 on 7/12/22, and that he had a stage 3 pressure injury. PT-I stated that due to R9's history of polio, he lacked internal rotation of his left leg and was a high risk for a pressure injury because of that. PT-I could not say if the pressure injury was preventable, as she was unaware if the facility had been using preventive measures prior to discovering the wound. PT-I stated she gave R9 a off-loading boot for his left foot on 7/12/22. During an observation on 7/13/22, at 1:30 p.m. with LPN-A, observed R9's pressure injury to left lateral ankle. Visually, wound appeared to measure approximately .25 x .25 inches, pale yellow in center, no scab, no drainage. Skin surrounding wound was slightly red. LPN-A stated it was healing and looked better. Wound was flushed and dressed by LPN-A. A pressure reducing mattress on bed and pressure reducing cushion in wheelchair were observed; neither were noted on R9's care plan. During an observation on 7/14/22, at 7:50 a.m.,	2 900		

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2 900	Continued From page 13 R9 was laying in bed, supine. Off-loading boot noted on left foot. During an interview on 7/14/22, at 8:17 a.m., (NA)-D stated R9 "depends on us for everything." NA-D stated R9 might be able to turn onto his side in bed by himself, but would need a pillow behind his back to keep him on his side. "We are supposed to reposition him every two hours, but he usually refuses." In the EMR, in the section where NA's documented cares, NA-D displayed tasks for the surveyor to review, it identified repositioning every two hours and for skin observations. Skin observations were marked as "red areas" five times prior 6/25 (6/16, 6/18, 6/19, 6/22, 6/23), when the pressure injury was discovered. NA-D stated a NA could only checkmark red area, but not indicate where the red area was located, but if she observed a red area, she would tell a nurse. NA-D stated she had never observed redness on R9's outer left ankle when bathing or dressing him. During an interview on 7/14/22, at 8:56 a.m., registered nurse (RN)-E looked in the EMR to determine R9's pressure injury was first observed on 6/25/22. RN-E indicated she did not hear much from staff about things like this (pressure injury). RN-E did not know what preventative measures had been in place to prevent a pressure injury to R9's ankle, stating, "Honestly, I'm not sure." RN-E looked at R9's care plan in the EMR and stated there were no interventions to prevent pressure injury over bony prominence's ...only daily skin inspection and to keep R9's skin clean and dry. RN-E acknowledged she was aware of R9's post-polio syndrome diagnosis and stated the care plan only addressed that diagnosis as it related to activities of daily living deficits. RN-E stated the facility	2 900		

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2 900	Continued From page 14 used a program that automatically populated care plan interventions, and as staff got to know a resident better, they added more interventions. RN-E acknowledged that had not been done with R9's care plan regarding pressure injury prevention. RN-E stated skin audits were done by nurses and that ankles were a part of the audit, adding that nurses were supposed to go through each body part noted on schematic body drawings on the audit form. RN-E stated she did not know how R9's skin condition on his ankle was overlooked before becoming a stage 3 pressure injury. While looking at the NA task list in the EMR, RN-E stated NA's were to "shift and reposition R9 in bed or chair every two hours to reduce pressure," and stated this had not been added to R9's care plan and therefore nurses might not have been aware of it. On the same task list, NA's were to observe R9's skin for scratches, red areas, discoloration, skin tears, and open areas. In the days prior to 6/25, there were checkmarks made by NA's on six days for "red areas," but no corresponding documentation indicating whether or not a nurse had been informed of this, or where the red areas were located. RN-E acknowledged the pressure injury on R9's ankle was "probably" preventable, adding they could have floated his heels; he could have had heel boots. During an interview on 7/14/22, at 10:21 a.m., the DON confirmed he was aware of R9's pressure injury to his left ankle. Discussed the lack of measures initiated to prevent pressure injury over bony prominence's, as well as NA's checking "red areas" in their documentation for skin observation, but no correlating progress notes to indicate a nurse was informed and the location of the red area. The DON acknowledged both were accurate. When asked if the pressure injury could	2 900		

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2 900	Continued From page 15 have been prevented, the DON replied, "Ultimately, hindsight is 20/20.... probably could have been prevented...we've prevented a pressure injury for a long time, considering how often R9 refuses cares." Other than a pressure relieving mattress, there was no evidence that pressure reducing measures were in place to protect R9's skin over bony prominence's prior to discovery of a pressure injury on 6/25/22. While there were multiple notation in progress notes regarding refusals of care or of activities, none were observed regarding refusals to reposition in bed. Facility policy titled Skin Alteration Management, undated, indicated the facility would identify and review residents whose clinical conditions increase the risk for skin breakdown. To ensure necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and new injuries from developing. On admission, and quarterly, each resident would have a Braden assessment. Appropriate interventions would be implemented based on assessment and would be placed on resident care plan. Resident's skin would be observed daily with cares and as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure care and services are implemented to prevent development of pressure ulcers. The DON or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the facility Quality Assurance Committee.	2 900		

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2 900	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care to 1 of 2 resident (R22) reviewed for activities of daily living (ADL) and who was dependent upon staff for care. Findings include: R22's significant change Minimum Data Set (MDS) assessment dated 6/18/22, indicated R22 had moderately impaired cognition, clear speech, was understood when he spoke and was able to understand others. R22 had adequate vision and minimal difficulty hearing. R22 required extensive assistance of one staff for personal hygiene. R22's care plan dated 5/6/22, indicated an ADL self-care performance deficient requiring extensive assistance of one staff for grooming and personal hygiene. During an interview and observation on 7/11/22,	2 920	Policy reviewed on 7/15/2022. Certified Nurse Aides and Nurses were educated on 7/14/2022. CNA-E was educated on 7/13/2022 in regards to policy of toenail trimming and nail trimming. Staff to continue to monitor nails and trim as necessary. Resident R22 did have his nails trimmed at time of survey. All resident□s nails were checked and trimmed as necessary. Director of nursing and Resident care coordinators to will randomly audit nails to assure compliance. Audits will be completed and brought to quarterly QAPI meeting for review and acceptance. All negative findings will be reported to the DON/ RCC to be immediately addressed. All pertinent staff will be educated on nail trimming by Director of Nursing on 8/11/2022.	8/14/22

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2 920	Continued From page 17 at 6:24 p.m., observed fingernails on both hands approximately one quarter inch or more past the top of each finger on both hands. R22 stated he wanted his nails trimmed but didn't have a nail clipper. R22 denied staff had offered to trim his nails on his weekly bath day. During an observation on 7/13/22, at 8:15 a.m., R22 was sitting in his wheelchair eating breakfast and stated he just had a shower. Fingernails were unchanged from observation on 7/11/22. During an interview on 7/13/22, at 8:35 a.m., nursing assistant (NA)-E stated NA's trimmed resident fingernails if they were not diabetic, and this would typically be done on bath day or whenever a resident wanted it done. NA-E stated R22 had a shower by (NA)-D. During an interview on 7/13/22, a 9:03 a.m., (NA)-G stated resident fingernails were trimmed on bath day by a NA and R22 should have had his nails trimmed since he had a shower. NA-G looked at R22's fingernails and stated they were long and thick. NA-G stated if a NA was not comfortable trimming a residents nails, he/she could ask for help. During an interview on 07/13/22, at 9:11 a.m., registered nurse (RN)-C looked at R22's nails and asked R22 if he liked that length or if he wanted them trimmed. R22 motioned with his hands as if he were using a fingernail clipper. RN-C stated...you'd like them trimmed....we'll do that. RN-C stated she would have expected R22's nails be trimmed with his shower this week or last week, and acknowledged the length of his nails was more than just one or two weeks growth. At 10:01 a.m., RN-C reported that she trimmed R22's fingernails.	2 920		

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2 920	Continued From page 18 During an interview on 7/14/22, at 8:12 a.m., (NA)-D stated she did not trim R22's nails with his shower on 7/13, because she did not know if R22 was diabetic, adding she later learned it was toenails of diabetic residents she could not trim. NA-D stated she had cleaned under R22's nails and noticed they were long and had planned to trim them later that shift. NA-D acknowledged the growth of R22's nails did not occur in just the past week, stating "no, they were too long" for that to be the case. During an interview on 7/14/22, at 10:21 a.m., the director of nursing (DON) stated he expected staff to assist residents with nail care. The DON stated NA-D had planned to trim R22's fingernails later that shift on 7/13/22. The DON was informed R22's fingernails were very long and were not the result of missing one nail trimming. Facility policy titled Activities of Daily Living, undated, indicated in part that the purpose was to provide assistance to residents as necessary and to improve quality of life. The policy did not specify nail care for residents, such as who was responsible for nail care or when it would be completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain grooming needs. The director of nursing or designee could review polices and procedures, educates staff and implement audit tools to monitor compliance. Audit results could be reported to the QAPI committee for further recommendations related to ongoing compliance.	2 920		

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2 920	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain a system to analyze monthly surveillance data for trends and patterns to reduce the spread of illness, infections, control transmission of infections and communicable diseases present in the facility, review annually the infection prevention and control program (IPCP), and the facility failed implement measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms. This had the potential to affect all 57 residents who resided in the facility. Findings include: Surveillance: Review of the facility's infection tracking sheets dated April 2022, to July 2022, indicated: resident, floor/wing, room number, infection type, body system of infection, community onset, facility onset, symptoms, onset date, device type,	21375	Infection control nurse educated staff on 7/11/2022 regarding proper doffing of PPE for Res#2. Infection control nurse educated the staff on how and where to take PPE off. FM-A was also educated. Policy and procedures reviewed. Following correction nursing will audit PPE doffing to ensure proper technique. For all residents under quarantine and/or isolation signage will be provided in room and upon admission. Audits will be done weekly at random and brought to quarterly QAPI meeting for review and acceptance. Infection control nurse to track all infections on infection and antibiotic tracking tool spreadsheet. Infection control nurse educated on tracking all infections, both infections that are being treated with antibiotics and those not being treated by antibiotics on the spread sheet. All infections will be tracked and monitored for trends. Res# 2 was added to the current infections and antibiotic tracking tool spreadsheet to bring it	7/15/22

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21375	Continued From page 20 infection risk factors, collection date, type of test, specimen source, results (organism colony counts for urine), antibiotic resistant organism, number of different antibiotics currently prescribed, drug (dose, route frequency), total days of therapy, antibiotic times outs performed, total days of therapy, transmission based precautions required, date symptoms resolved. The facility tracking sheets dated April 2022, to July 2022, indicated missing data fields on the tracking sheets, and further lacked an analysis of the infections/illness, patterns or trends, interventions implemented, and transmission based precautions required. The facility did not provide analysis of the infections to include trending, patterns and what interventions were implemented, if patterns or trends were identified. The facility further failed to identify surveillance of R2's Clostridium difficile (infection of the large intestine) and transmission based precautions. R2's lab information dated 4/20/22, indicated a positive C. difficile toxin. On 7/13/21, at 1:04 p.m. an interview with registered nurse (RN)-B indicated she was the infection nurse at the facility. RN-B verified she tracked and documented infections on the computer tracking form, but no ongoing "formal" surveillance, monitoring of trends and/or breaks in infection practices had occurred more then quarterly. RN-B indicated infection data was reviewed on a quarterly basis to report the infection rate to the quality committee. When asked to review the infection data, RN-B used the tracking form on the computer and identified the infection control logs for the past few months. RN-B confirmed the some of the data was missing from the tracking logs. RN-B verified anything she had done regarding infection prevention was on done on an "informal" basis.	21375	current on 7/13/2022. QAPI committee met 8/3 to discuss findings and route cause of deficiency which indicated the need for continued education. Director of Nursing and Infection Control Nurse will audit spreadsheet weekly to ensure compliance with all residents that need to be tracked and brought to quarterly QAPI meetings for review and acceptance. All pertinent staff will be educated for resident PPE doffing and educated for resident infection and antibiotic tracking by Director of Nursing on 8/11/2022.	

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21375	Continued From page 21 RN-B indicated daily she discussed residents on antibiotics with facility staff; however, residents were not tracked or compared for trending's or patterns. RN-B verified a monthly analysis of the illness' and infections was important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. RN-B indicated R2 was not on the surveillance tracking sheet. RN-B verified R2 was expected to be on the surveillance tracking sheet starting April 2022, and was expected to be on the current tracking log dated July 2022, due to R2 continued transmission based precautions, C-diff diagnoses, and symptoms of diarrhea. On 7/14/22, at 10:32 a.m. the director of nursing (DON) indicated the facility was expected to track, trend and analyze potential and actual infections of residents; and further indicated the current facility practice was to analyze the data collected from the tracking log and summarize the information quarterly. The information was then brought to the quality assurance meeting and discussed on a quarterly basis. The DON confirmed R2 was expected to be on the tracking log due to transmission based precautions and diagnosis of C-Diff. Policy titled Transmission Based Precautions dated 4/13/22, indicated: Surveillance and Outbreak Management 1. In order to detect outbreaks early and monitor the effectiveness of these policies: a. confidential line listing of residents known to carry antibiotic resistant microorganisms (ARM) should be maintained. b. Surveillance of cultures obtained for clinical reasons should be reviewed regularly to determine if nososcomial transmission has	21375		

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21375	Continued From page 22 occurred. 2. An outbreak is defined as: a. three or more cases of clinically significant facility acquired infections caused by the same Organism occurring in the same general area within up. Of seven days or b. twice that normal number of these infections per month observer period of three consecutive months Policy Titled Antibiotic Stewardship Program dated 5/17/18, indicated: -Stewardship actions are conducted to enable or to measure these key elements of care knowing when to be concerned about their infection and or resident what clinical and historical information to gather for the provider, when does submit diagnostic specimens to the laboratory, how to quantify and assess appropriateness of antibiotics prescribed, and how do I identify adverse outcomes that might be associated with antibiotics. actions put into place Find the antibiotic stewardship team will be monitored monthly (see measuring actions section of this document), discuss with leadership and appropriate consulting experts and reviewed for necessary updates annually. Actions: -Prescription record keeping dose duration route and indication of every antibiotic must be documentation in the electronic medical record for every resident regardless of prior prescriptions or documentation elsewhere. location of this information should be made on the day that the prescription is written or on the day the resident returns the facility on an antibiotic prescribed elsewhere. records will be reviewed monthly to assess compliance with this requirement as well as prescription appropriateness for the individual	21375		

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21375	Continued From page 23 resident site and type of infection. Tracking a. Measurement/tracking objectives: we will monitor antibiotic use stewardship actions and outcomes related to antibiotic use in order to guide change and track antibiotics to recheck program impact b. what will be measured tracked i. antibiotic use: antibiotic starts ii. stewardship actions: record keeping protocol compliance iii. Outcomes: C difficile and MRSA detection c. Measurements: i. Antibiotic use: days of therapy ii. stewardship actions: record keeping protocol compliance and compliance with urine specimen submission guidelines iii. outcomes: C difficile MRSA infections urinary tract infections and antibiotic cost Infection prevention and control program (IPCP): Review of the facility infection prevention and control program (IPCP) dated 3/23/21, indicated manual and policies reviewed. On 7/13/21, at 1:04 p.m. an interview RN-B confirmed the IPCP was last reviewed on 3/21/21, and verified IPCP were expected to be reviewed annually. Personal Protective Equipment (PPE): During observation on 7/11/22, at 12:33 p.m. observed an unidentified staff exit R208's room, removed PPE that included gown, gloves, N-95 mask, and face shield, and removed and discarded contaminated gown into a container that would not close due to overfilled with other	21375		

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21375	Continued From page 24 yellow gowns. During observation on 7/11/22, at 12:40 p.m., 12 feet outside of R2's room a cart with drawers with clean PPE supplies was observed, and on each side of the clean PPE supplies a container for dirty linens and dirty PPE supplies was observed. R2's room was observed and failed to have signage posted regarding transmission based precautions, and R2's room did not have garbage for staff to remove contaminated PPE prior to exiting the room. During interview on 7/11/22, at 1:57 p.m., RN-B indicated staff received training on donning and doffing PPE. RN-B stated staff were taught to take all PPE off inside the room and stated staff were expected to take off PPE prior to exiting the resident's room. RN-B stated the garbage's to dispose of PPE were expected in the residents room not outside the resident's room. On 7/11/22, at 2:20 p.m. R258's family member was observed in R258's room, and wore a PPE gown and FM-A was observed to exit the room, walked down unit hallway with isolation gown, stopped at unit coffee machine, lifted lever to coffee machine, poured coffee into Styrofoam cup. FM-A returned to R258's room, opened door, and closed door behind her once in room. Outside of R258's room, observed 2 garbage cans outside of resident room, one labeled "soiled," had red bag lining garbage can and other not labeled, had regular plastic lining garbage can. Noted yellow isolation gowns, gloves, N95 masks in regular garbage can. Next to garbage cans was a clean PPE cart with supplies. On 7/12/22, at 11:11 a.m. nursing assistant	21375		

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21375	Continued From page 25 (NA)-C, indicated R2 was on precautions for C-diff, and indicated staff were expected to wear gown and gloves, when they assisted with R2 with toileting. NA-C further indicated residents who are newly admitted to the facility were isolated their room for 14 days, and staff were expected to wear PPE including gowns, gloves, face, shield, N95 when going to the room, and the PPE was discarded when exiting the room not in the room. On 7/12/22, at 1:07 p.m. registered nurse (RN)-A came out of R258's room, had yellow isolation gown on over scrubs, gloves, N95 mask, face shield and discarded PPE in regular garbage can outside of R258's room. On 7/13/22, at 9:14 a.m. RN-A indicated R258 was on isolation precautions due to not up to date with COVID booster immunization. RN-A indicated would not expect R258;s family member walk around hallway/dining area with isolation gown/mask after she came out of R258's isolation room. RN-A further indicated with PPE garbage cans outside of room, there is potential if R258 was infectious, would pose risk for transmission of infections to others and RN-A indicated garbage cans should be inside R258's room for potential exposure/cross-contamination. On 7/13/22, at 9:49 a.m. RN-C indicated FM-A was not expected walking throughout facility with isolation gown/mask after coming out of R258's isolation room. RN-C stated staff were expected provide education with FM-A to remain in the room until ready to leave facility. During a follow up interview on 7/13/22, at 1:04 p.m. RN-B indicated R2 did not want signage on her door related to transmission based	21375		

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21375	Continued From page 26 precautions, and did not want the garbage in her room for PPE discarded, when asked how other resident's would be protected RN-B indicated she was not sure what the policy stated and staff were educated on 7/12/22, remove PPE just inside doorway, dispose of in bag, and tie securely, proceed to receptacle in hallway and sanitize hands after disposing . RN-B confirmed prior to 7/12/22, staff were removing PPE outside of R2's doorway. During interview on 7/14/22, at 10:32 a.m. the director of nursing confirmed staff should not be coming out of the room to discard the gowns. Progress note dated 7/11/22, at 4:24 p.m. RN-B indicated R2's receptacles for laundry and garbage are too far out into the hall for IC (infection control) best practice. R2 does not want them in her room or closer to the door, she refuses signage on her door. New procedure to ensure good IC will be: take a garbage bag from drawer in bathroom, proceed to door way, remove PPE just inside doorway, dispose of in bag, and tie securely. Proceed to receptacle in hallway and sanitize hands after disposing. Please do the same with laundry,. Policy titled Transmission-Based Precautions dated 4/13/22, indicated: Gowns 1. DON gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident care environment. 2. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental services that could result in possible transfer microorganism to other residents environmental services. 3. for all residents gowns should be worn as	21375		

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21375	Continued From page 27 necessary for standard precautions. 4. In addition, a clean, non sterile gown with long sleeves will be worn if direct care will be provided or when substantial contact with secretions/excretions is anticipated when such contact is anticipated the gown should be put on before entering the room or approaching the resident 5. Gowns should also be worn when body contact with environmental services and items in the room that may be contaminated is anticipated. Particularly if the resident is incontinent of urine or stool or has diarrhea 6. The gown will be removed and appropriately discarded before leaving the residents environment. 7. After gown removal, staff should ensure that clothing does not potentially contaminate environmental services to avoid transfer microorganisms to other residents or environments. Policy and procedure title personal protective equipment- gowns, aprons and lab coats dated 10/14/21, indicated: -When gowns are used, they must be used only once and discarded into appropriate receptacles located in the room in which the procedure is performed. Staff Training document titled Infection Control: Essential Principles dated 2020, indicated: -Perform hand hygiene and put on gloves before you enter the persons room. for some tasks you may need to wear a gown. before you leave the room remove your gloves and your gown and perform hand hygiene these precautions apply to family and other visitors as well.	21375		

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21375	Continued From page 28 SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility. The DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		7/15/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 29 by: Based on interview, observation, and document review, the facility failed to ensure a tuberculosis screen was completed for 6 of 6 residents (R2, R3, R31, R208, R209, R258) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention. Findings include: Review of resident's electronic medical records (EMR) identified the following: R2 was admitted to the facility on 7/14/21. No TB screen was completed 90 days prior to or within 72 hours of admission. Documentation of TB symptom screen was requested. No TB symptom screen documentation was provided. R3 was admitted to the facility on 3/23/22. No TB screen was completed 90 days prior to or within 72 hours of admission. Documentation of TB symptom screen was requested. No TB symptom screen documentation was provided. R31 was admitted to the facility on 5/12/22. No TB screen was completed 90 days prior to or within 72 hours of admission. Documentation of TB symptom screen was requested. No TB symptom screen documentation was provided. R208 was admitted to the facility on 7/6/22. No TB screen was completed 90 days prior to or within 72 hours of admission. Documentation of TB symptom screen was requested. No TB symptom screen documentation was provided. R209 was admitted to the facility on 6/21/22. No TB screen was completed 90 days prior to or within 72 hours of admission. Documentation of	21426	Director of Nursing and/or Resident Care Coordinators (RCC) to ensure that all new admissions will be assessed with a new admission Mantoux assessment. This will be completed via an update of the current admission assessment or with the assessment called New resident Mantoux Screening 1.1. Immediate education to nursing staff on new assessment on 7/14/2022. Following correction DON will audit each new admission to make sure the assessment is completed timely. This will be done on all new residents in the building. The audit will be brought to quarterly QAPI meeting for review and acceptance. All pertinent staff will be educated for resident Mantoux assessments by Director of Nursing on 7/11/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	C 07/14/2022

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21426	Continued From page 30 TB symptom screen was requested. No TB symptom screen documentation was provided. R258 was admitted to the facility on 208. No TB screen was completed 90 days prior to or within 72 hours of admission. Documentation of TB symptom screen was requested. No TB symptom screen documentation was provided. An interview on 7/13/22, at 10:16 a.m. with with registered nurse (RN)-B indicated she was the infection nurse at the facility and responsible for the residents TB screening and TST (tuberculin skin test) administration and further verified all residents had not completed TB symptom screen 90 days prior to admission or within 72 hours of admission. Review of the facility Policy and Procedure Tuberculosis Infection Control Program undated, indicated: - residents were to have a two-step TST within 72 hours of admission or previous screening within 90 days of admission unless contraindicated following regulations set forth by the Department of Health. The facility's TB policy did not include a revision date, and did not include resident active TB symptom screening. The document titled, Facility Tuberculosis (TB) Risk Assessment Instruction and Worksheet for Health Care Settings Licensed by MDH dated 1/17/22 included: o TB patient screening: o Baseline TB screening of patients is required at time of admission for health care settings licensed as board care homes and nursing homes o Baseline TB screening includes: (1) two-step TST or single TB blood test, (2) TB symptom	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	C 07/14/2022

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21426	Continued From page 31 screen, and (3) assessment of the patient's risk factors for TB exposure and progression. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees. The ICN, DON and/or designee could audit resident admissions as well as current residents records to ensure compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		